6.b. Optometric Services.

Eligible medical assistance recipients covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program receive optometric and eyeglasses services through that program as described elsewhere in this State Plan. Eligible medical assistance recipients not eligible for the EPSDT program will be entitled to optometric services as described below and elsewhere in this State Plan, when provided by a physician, optometrist, or optician enrolled in the Texas Medica Assistance Program at the time the service(s) is provided.

Each eligible recipient, other than EPSDT recipients, is entitled to one eye exam by refraction every two state fiscal year period (a 24 consecutive months biennial period from September 1, through August 31), whether performed by a Doctor of Optometry or a physician (M.D. or D.O.). This limit of one eye refraction per recipient, per every two state fiscal year period, applies to both prosthetic (aphakic) eyewear and nonprosthetic eyewear. Payment will not be made by the Texas Medical Assistance Program for more than one eye refraction, per recipient, per every two state fiscal year (24 months) period. This limit does not apply to other diagnostic and/or treatment of the eye for medical conditions, other than determination of visual acuity. Diagnostic and treatment services provided by an optometrist are covered by the Texas Medical Assistance Program if the services are (1) within the optometrist's scope of practice, as defined by state law and (2) reasonable and medically necessary as determined by the single state agency or its designee. Other diagnostic and treatment services provided by a physician are described elsewhere in this State Plan.

Prosthetic eyewear, including contact lenses and glass or plastic lenses in frames, is a program benefit provided to an eligible recipient if the eyewear is prescribed for post cataract surgery, congenital absence of the eye lens, or loss of an eye lens because of trauma. Reimbursement is made for as many temporary lenses as are medically necessary during post surgical cataract convalescence (the four-month period following the date of cataract surgery). One pair of permanent prosthetic lenses can be dispensed as a program benefit. However, reimbursement is made by the program for the repair or replacement of lost or destroyed prosthetic eyewear and the replacement of prosthetic eyewear when it is required because of a change in visual acuity of .5 diopter or more.

Repairs to prosthetic eyewear are reimbursable if the cost of materials exceeds $2. Repairs costing less than $2 are not reimbursable by the program and the provider may not bill the recipient for these services.

Optometric services provided in skilled or intermediate care facilities are reimbursable by the program if the recipient's attending physician has ordered the services(s) and the order is included in the recipient's medical records at the nursing facility.

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6.c. Chiropractic Services.

Coverage of chiropractic services is limited to services which consist of necessary treatment or correction by means of manual manipulation of the spine, by use of hands only, to correct a subluxation demonstrated by x-ray to exist. The x-ray must be done prior to such treatment. The chiropractor must be licensed to practice when and where the services are performed and must meet the uniform minimum standards promulgated by the Secretary of the Department of Health and Human Services under Title XVIII of the Social Security Act.

Coverage for such treatment is limited to no more than 12 visits per recipient per 12 consecutive month period. A 12 consecutive month period begins with the first month in which services are provided.*

Documenting x-rays will be kept on file and are subject to utilization review and audit procedures. Coverage of chiropractic services will be determined by the single state agency or its designated agent in accordance with the regulations, rules and procedures governing chiropractic services under Part B of Title XVIII of the Social Security Act. Coverage does not extend to the diagnostic, therapeutic services or adjunctive therapies furnished by a chiropractor or by others under his or her orders or direction. This exclusion applies to the x-ray taken for the purpose of determining the existence of a subluxation of the spine. Additionally, braces or supports, even though ordered by an M.D. or D.O. and supplied by a chiropractor, are not reimbursable items.

* Durational, dollar, and quantity limits are waived for recipients of EPSDT services. Services allowable under Medicaid laws and regulations may be covered when medically necessary for these recipients.

6.d(1) Other Practitioners' Services.

Audiologists' Services. Audiologists' services for the provision of hearing aids only. See Item 12.c.

6.d(2) Psychologists' Services. Psychological counseling and services provided by a licensed psychologist are covered if the services (1) are within the psychologist's scope of practice, as defined by state law; and (2) would be covered by the Texas Medical Assistance Program when they are provided by a licensed physician (M.D. or D.O.).

Psychologists' services must be provided by a licensed psychologist enrolled in and approved for participation in the Texas Medical Assistance Program. A psychologist is defined as a person who is licensed to practice as a psychologist in the state in which the service is performed.

Services performed by a psychological assistant or associate are not benefits of the Texas Medical Assistance Program.

Licensed psychologists who are employed by or remunerated by a physician, hospital, facility, or other provider may not bill the Texas Medical Assistance Program directly for psychologists' services if that billing would result in duplicate payment for the same services. If the services are covered and reimbursable by the program, payment may be made to the physician, hospital, or other provider (if approved for participation in the Texas Medical Assistance Program) who employs or reimburses the licensed psychologist. The basis and amount of Medicaid reimbursement depends on the services actually provided, who provided the services, and the reimbursement methodology utilized by the Texas Medical Assistance Program as appropriate for the services and provider(s) involved.

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6.d.(3) Certified Registered Nurse Anesthetists' Services. Subject to the specifications, conditions, requirements, and limitations established by the single state agency, anesthesia services provided by a certified registered nurse anesthetist (CRNA) are covered by the Texas Medical Assistance Program. A CRNA is defined as a registered nurse who is approved as an advanced nurse practitioner by the state in which he or she practices and who is currently certified by either the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists.

Covered services must be provided by a CRNA enrolled and approved for participation in the Texas Medical Assistance Program. The CRNA must sign a written provider agreement with the single state agency. By signing the agreement, the CRNA agrees to comply with the terms of the agreement and all requirements of the Texas Medical Assistance Program, including regulations, rules, handbooks, standards, and guidelines published by the single state agency or its designee. The CRNA must bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the single state agency or its designee.

The Texas Medical Assistance Program will not reimburse the CRNA for equipment or supplies. Equipment and supplies are the responsibility of the facility in which the CRNA services are provided. If the equipment and supplies are covered and reimbursable by the Texas Medical Assistance Program, payment may be made to the facility if the facility is approved for participation in the Texas Medical Assistance Program. The basis and amount of reimbursement depends on the reimbursement methodology utilized by the Texas Medical Assistance Program for the services and providers involved.

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6.d.(4) Other Categories of Advanced Nurse Practitioner Services

Advanced nurse practitioner--A registered professional nurse, currently licensed in the State of Texas, who is prepared for advanced nursing practice by virtue of knowledge and skills obtained through a post-basic or advanced educational program of study acceptable to the Board of Nurse Examiners for the State of Texas. The advanced nurse practitioner is prepared to practice in an expanded role to provide health care to individuals, families, and/or groups in a variety of settings. The advanced nurse practitioner functions in a collegial relationship with other health care professionals making independent decisions about nursing needs and interdependent decisions with health care professionals regarding health regimens.

In addition to coverage of services performed by certified nurse midwives, certified registered nurse anesthetists, certified pediatric nurse practitioners, and certified family nurse practitioners described elsewhere in this state plan and subject to the specification, conditions, requirements, and limitations established by the Single State Agency or its designee, services performed by advanced nurse practitioners are covered if the services: 1)are within the scope of practice for advanced nurse practitioners, as defined by state law; 2) are consistent with rules and regulations promulgated by the Board of Nurse Examiners for the State of Texas or other appropriate state licensing authority; and 3) would be covered by the Texas Medical Assistance Program if provided by a licensed physician (M.D. or D.O.).

To be payable, services must be reasonable and medically necessary as determined by the Single State Agency or its designee.

The advanced nurse practitioner must comply with all applicable federal and state laws and regulations governing the services provided; be enrolled and approved for participation in the Texas Medical Assistance Program; sign a written provider agreement with the Single State Agency or its designee; comply with the terms of the provider agreement and all requirements of the Texas Medical Assistance Program, including regulations, rules, handbooks, standards, and guidelines published by the Single State Agency or its designee; and bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the Single State Agency or its designee.

Advanced nurse practitioners who are employed or remunerated by a physician, hospital, facility, or other provider must not bill the Texas Medical Assistance Program directly for their services if that billing would result in duplicate payment for the same services. If the services are coverable and reimbursable by the program, payment may be made to the physician, hospital, or other provider (if the provider is approved for participation in the Texas Medical Assistance Program) who employs or reimburses advanced nurse practitioners. The basis and amount of Medicaid reimbursement depend on the services actually provided, who provided the services, and the reimbursement methodology determined by the Texas Medical Assistance Program as appropriate for the services and the providers involved.

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6.d.(5) Licensed Master Social Worker-Advanced Clinical Practitioner (LMSW-ACP) Services. Mental health counseling services for emotional disorders or conditions provided to Medicaid eligible clients by a licensed master social worker-advanced clinical practitioner (LMSW-ACP) are covered services. To be payable, the services must be reasonable and medically necessary as determined by the department or its designee.

To be considered for reimbursement by the Texas Medical Assistance Program, LMSW-ACPs must be licensed as a master social worker and be recognized as being qualified for the practice of clinical social work by the Texas State Board of Social Worker Examiners. These providers must comply with all federal and state laws and regulations governing the services provided

Participating LMSW-ACPs must be enrolled Medicare and the Texas Medical Assistance Program and comply with all of the terms of the provider agreement and all of the regulatory provisions published by the department or its designee.

LMSW-ACPs who are employed or remunerated by another provider may not bill the Texas Medical Assistance Program directly for counseling services if that billing would result in duplicate payment for the same services.

6.d.(6) Licensed Professional Counselor (LPC). Mental health counseling services for emotional disorders or conditions provided to Medicaid eligible clients by a licensed professional counselor (LPC) are covered services. To be payable, the services must be reasonable and medically necessary as determined by the department or its designee.

To be considered for reimbursement by the Texas Medical Assistance Program, LPCs must be licensed by the Texas Board of Examiners of Professional Counselors in accordance with the Texas Licensed Professional Counselor Act. These providers must comply with all federal and state laws and regulations governing the service provided. Participating LPCs must be enrolled in the Texas Medical Assistance Program and comply with all of the terms of the provider agreement and all of the regulatory provisions published by the department or its designee.

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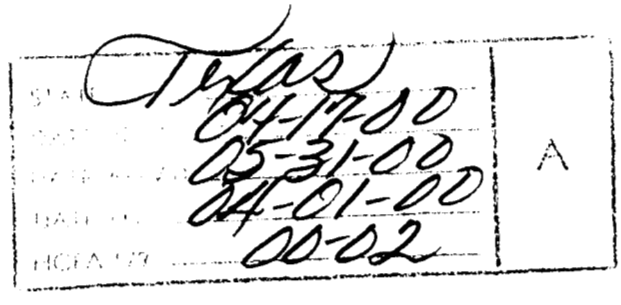
6.d.(6) Continued.

LPCs who are employed or remunerated by another provider may not bill the Texas Medical Assistance Program directly for counseling services if that billing would result in duplicate payment for the same services.

6.d.(7) Licensed Marriage and Family Therapist (LMFT). Mental health counseling services for emotional disorders or conditions provided to Medicaid eligible clients by a licensed marriage and family therapist (LMFT) are covered services. To be payable, the services must be reasonable and medically necessary as determined by the department or its designee.

To be considered for reimbursement by the Texas Medical Assistance Program, LMFts must be licensed by the Texas Board of Examiners of Marriage and Family Therapists in accordance with the Texas Licensed Marriage and Family Therapist Act. These providers must comply with all federal and state laws and regulations governing the service provided Participating LMFTs must be enrolled in the Texas Medical Assistance Program and comply with all of the terms of the provider agreement and all of the regulatory provisions published by the department or its designee.

LMFTs who are employed or remunerated by another provider may not bill the Texas Medical Assistance Program directly for counseling services if that billing would result in duplicate payment for the same services.



SUPERSEDES: TN • 95-03

7. Home Health Care Services.

In accordance with the provisions or specifications established by the single state agency, home health care services are as follows:

A. Authorized services, supplies, equipment or appliances must be suitable for and provided to an eligible recipient in his place of residence, but not including as a residence a hospital, or a nursing facility.

B. The recipient for whom home health care services are authorized must be under the continuing care and supervision of a licensed physician.

Medical necessity criteria include the homebound determination. That is, the individual has a condition due to illness or injury which restricts a recipient's ability to leave home, or which makes leaving the home taxing or requires considerable effort, or is medically contraindicated.

Exceptions to the homebound requirement: 1) those patients who only require insulin syringes and needles with a physician's prescription from a participating pharmacy 2) those recipients who are eligible for the EPSDT program and 3) those patients who require diabetic supplies and related testing equipment.

C. Services, supplies, equipment or appliances must be prescribed by a physician as medically necessary and as a part of the physician's plan of treatment for the recipient and will be available only upon the physician's written signed and dated plan of care.

D. All home health benefits require prior authorization for payment, unless otherwise specified by the single state agency's health insuring agent and must be furnished by a Title XIX home health agency or a durable medical equipment/supplier enrolled to provide Title XIX home health services. Insulin syringes and needles are obtained with a physician's prescription from a participating pharmacy and do not require prior authorization.

E. To be approved as a Title XIX home health agency or home health durable medical equipment/supplier, the home health agency or durable medical equipment/supplier, must be approved as a Title XVIII (Medicare) home health services provider or durable medical equipment/supplier and must be enrolled with the single state agency.

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F. Services are limited to:

(i) Part-time or intermittent professional nursing services provided by a registered nurse or licensed vocational nurse with appropriate supervision furnished through a Title XIX home health agency or by a registered nurse when no home health agency exists in the area.

(ii) Services of a home health aide who has been assigned by a professional registered nurse and who is under the supervision of a professional registered nurse, physical therapist or occupational therapist.

(iii) Visits by either a nurse or a home health aide as defined under this program.

(iv) Certain medical supplies, equipment and appliances suitable for use in the recipient's place of residence.

(v) Physical therapy services are available only for treatment of acute musculoskeletal or neuromuscular conditions or acute exacerbations of chronic musculoskeletal or neuromuscular conditions.

(vi) Occupational therapy services are available for the evaluation and function-oriented treatment of individuals whose ability to function in life roles is impaired by recent or current physical illness, injury or condition. There must be specific goals to achieve a functional level within a reasonable amount of time based on the therapist's evaluation and the physician's assessment and plan of care.

(vii) For eligible recipients who are enrolled in Medicare, Medicare must be utilized as a primary resource for payment of home health benefits. Recipients who have exhausted their home health benefits under Medicare are not entitled to receive home health care services under this Title XIX State Plan or program.

Consideration may be given to payment of home health aide services, medical supplies, equipment, or appliances when a recipient enrolled in Medicare does not qualify for these home health services under Medicare because 1) skilled nursing, physical therapy or speech therapy is not an essential element of the patient's treatment plan; 2) when the medical supplies, equipment or appliances are not otherwise available under Medicare.

Durational, dollar, and quantity limits are waived for recipients of EPSDT services. Services allowable under Medicaid laws and regulations may be covered when medically necessary for these recipients.

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G. Services are limited to (Continued):

When the medical supplies, equipment or appliances are not otherwise available under Medicare.

(vii) Physical therapy services, when ordered by a physician and included in the physician's plan of care. Physical therapy benefits are available only for treatment of acute musculoskeletal or neuromuscular conditions or acute exacerbations of chronic musculoskeletal or neuromuscular conditions.